STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE PUBLIC HEALTH COMMITTEE
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Testimony Supporting Senate Bill No. 847

AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS REGARDING PUBLIC HEALTH

Senator Harris, Representative Ritter and distinguished members of the Public Health Committee thank you for the opportunity to offer written testimony in support of Senate Bill No. 847, An Act Concerning the Governor's Budget Recommendations Regarding Public Health.

Through this bill, Governor Rell is proposing measures which will result in cost-savings to Connecticut taxpayers while maintaining essential public health services for the state's citizens. Many of the measures are innovative proposals to strengthen regionalization in the state, consolidate services, and strengthen existing programs. This bill is required to implement the Governor's Budget for the Office of the Chief Medical Examiner, Department of Public Health and Department of Mental Health and Addiction Services.

Sections 1 and 2 of the bill require the Commission on Medicolegal Investigations (COMLI) to submit recommendations concerning the salaries of the Chief Medical Examiner and the Deputy Chief Medical Examiner to the Secretary of the Office of Policy and Management (OPM) for review and approval. Under current law, COMLI is authorized to increase the salaries of both the Chief Medical Examiner and the Deputy Chief Medical Examiner without further review and approval regardless of available funding. Requiring COMLI to submit recommendations to OPM for review and approval will ensure any salary adjustments are considered as part of the budgeting process and will ensure that the agency's personal services costs remain within budgeted levels over the biennium.

Sections 3 - 25 of the bill are required to implement the Governor's proposal to regionalize local departments of health. This bill defines regional departments of health as three or more municipalities with a combined population of no less than fifty thousand that have united for the purpose of regionalizing local health initiatives. This bill adjusts the per capita payments to regional departments of health to $1.25 per capita and eliminates reimbursements to non-regionalized local health departments. Municipalities must continue to employ either a full time or part time local health director, depending upon population. Municipalities that are not currently members of a regional health department may elect to join an existing region, or work with other municipalities to establish a new region. The restructured payments to local health departments are expected to save approximately $2.6 million in FY10 and $2.8 million in FY11.

Section 26 of the bill creates a comprehensive loan repayment assistance program for primary care professionals and health care educators. The new loan repayment assistance program will allow the Department of Public Health to offer incentives for primary care professionals and also individuals who educate health care professionals. Currently, the state faces a shortage of health care professionals, in part due to the need for more educators in the health care field. Two existing loan programs are combined and funding of $150,000 in FY10 and FY11 is recommended. The consolidation of the two programs will result in savings of $87,564 in FY10 and FY11.

Section 27 of the bill adds the provision that DPH's emergency medical services equipment and local system development grants are provided within available appropriations. The Governor's budget recommends elimination of funding for emergency medical services (EMS) training and EMS Regional Councils which will result in savings of $708,365 in FY10 and FY11.

Sections 28 - 50 of the bill contain technical modifications which change "district" to "regional" departments of health.

Section 51 - The Department of Mental Health and Addiction Services and the Department of Social Services are currently exploring whether pharmacy costs for DMHAS inpatients can be billed to Medicare Part D. If federal rules permit, DMHAS may be able to apply to join the network of long term care pharmacies and begin billing the federal government through Medicare Part D for pharmaceuticals, co-pays and expenses for certain inpatient clients. The proposed language will permit DMHAS to enter into this network and develop billing arrangements in order to maximize federal reimbursement opportunities. This provision could allow future savings in the Behavioral Health Medications account as well as maximization of federal reimbursement opportunities.

Section 52 permits DMHAS tobacco prevention and enforcement positions engaged in compliance activities required by the federal government as a condition of receipt of the Substance Abuse Prevention and Treatment Block Grant to be funded through the Drug Assets Forfeiture Account. This provision will support a DMHAS savings of $278,175 through shifting salaries for certain positions necessary to reduce tobacco purchases by minors to the Drug Assets Forfeiture Account.

Sections 56–60 propose changes to DMHAS' Pre-Trial Alcohol and Drug Treatment program. The language:

- re-names and expands the Pretrial Drug Education Program from a single "one-size fits all" 12-hour (8-session) intervention model to a multi-level offender-focused option for the courts:
  a 15-hour (10-session) intervention, or
  a 22.5-hour (15-session) "pre-treatment" intensive intervention, or
  active treatment.

- establishes an evaluation stage allowing for a professional, clinical evaluation of the offender which would be submitted to the court and include participant-focused recommendations for addressing their individual level of need.

- makes the drug education program comparable to the Pretrial Alcohol Education System making it more clinically responsive to the specific needs of the offender. A number of new referrals meet guidelines for substance dependency and are unlikely to have their needs adequately met by the current low-level 12-hour program. The proposal offers an expanded intervention and pre-treatment programming option together with the treatment option.

- makes it possible for the courts to refer youths charged with possessing or attempting to obtain alcohol to this expanded program. Currently such offenders do not have a professional evaluation of their possible needs and as a result may not receive an appropriate intervention. This proposal would create access to the same professional evaluation as other "possession" offenders and would result in an intervention tailored to their specific needs. This early evaluation and intervention approach is expected to reduce substance abuse and is being adopted by several other states.

- limits the possible delays in beginning the program. Currently, attorneys advise their clients that they needn't begin the program when the courts order it because of the extended case continuances that are associated with this program. These offenders then "fall between the cracks" and either fail to comply or attempt to complete the program at the last minute which often means further court continuances to complete it.

- limits the possible number of re-instatements to the intervention programs and requires a re-instatement fee. The current "unlimited" opportunity for re-instatements places an economic hardship on contracted providers because the current fees support costs for the first referral only; it also impacts program credibility as there is currently no consequence for program non-compliance other than a need to appear in court. Extreme cases can occur three or four times (o more) and extend the criminal case for several years.

- establishes a new fee structure commensurate with programming: evaluation, Level 1, and Level 2. Additionally the bill modifies the application fee (increasing from $50.00 to $100.00) to make it equivalent to the new application fee for the alcohol education program. The fee increases will result in an additional $400,000 in the account.

- permits up to $500,000 of any funds deposited or credited each year to the Pre-Trial account to be made available to the Department of Mental Health and Addiction Services for prevention programs including but not limited to tobacco cessation and substance use disorder education and prevention.

Section 61 requires DMHAS to expedite the closure of Cedarcrest Hospital. Section 62 of the bill defines priority state hospital project as each step, part, or aspect of consolidating Cedarcrest patients onto the campus of Connecticut Valley Hospital or in other inpatient or community settings. The bill establishes the parameters for projects as beginning no later than April 1, 2010 and completed no later than December 31, 2010 with a cost not to exceed $6.5 million. The section also exempts this closure from DPW statutes related to contracting for consultant services, bidding for public building contracts and prequalification requirements; exempts this project from Connecticut Environmental Policy Act requirements related to coordination of state plans and programs and evaluation by state agencies of actions affecting the environment and the public scoping process; and also exempts the agency from the certificate of need process as well as the state contracting standards board. The closure of Cedarcrest Hospital is anticipated to result in annualized savings of $3.3 million by FY11 and cost avoidance of $11 million in planned capital expenditures over the next 5 years.

Section 67 eliminates the Community Mental Health Strategy Board and its duties and the requirement for annual plans. The board was created to advise DMHAS on the types of services to be funded from FY01 surplus appropriations in the amount of $40 million. Those programs have been implemented and the funding annualized as part of the ongoing General Fund budget, so the board is no longer necessary. Sections 53, 54, 55, 63 and 64 eliminate references to Strategy Board participation on various oversight boards and studies. The Governor's budget assumes approximately $825,000 in revenue through the sweeping of the remaining balance in the Community Mental Health Strategic Investment Fund. This section also eliminates payments to local health departments that employ a part time local health director. Currently, municipalities with part time local health directors receive 0.49 cents per capita. The bill also repeals an obsolete statute that distributed excess funds to municipalities for the fiscal year ending June 30, 2000.

I would like to again thank the committee for the opportunity to present this written testimony. I respectfully request the Committee support this bill and, as always, my staff and I are available at your convenience to answer any questions you may have.